

IPOS FACTO (SIC)

The new millennium brings with it a new disease, curious in that it is specific to healthcare: the Internet Print Out Syndrome (IPOS). No longer is it enough to turn on, tune in and drop out, now it is turn on, log on, and drop in on your GP and give the poor infantry something else to worry about from some crazy website.

Actually, it could be worse than that. Another pestilence stalks the land which can interact with IPOS. It is the alternative/complementary/natural medicine phenomenon. This one compounds IPOS by castigating all conventional medicine as wrong and hateful, and why don't **YOU** know, recognise and acknowledge that anything natural must be better, safer, and in tune with the world.

Facts, just give us the facts

Bandolier is fed up with reading the guff that comes with our national newspapers, TV, radio, and, increasingly, the Internet. It is time for a spirited defence, and there is only one defence – facts, just give us the facts. Facts depend on quality, and quality can help sort the wheat from the chaff.

In the first few months of 2000, *Bandolier* will search out systematic reviews of alternative therapies. Many good and many bad reviews have been published in the last few years. *Bandolier* will examine their quality and hold them up for inspection. To date experience shows four ways in which alternative therapy reviews can produce negative results:

- 1 The review is awful. It fails to take account of sources of bias, includes non randomised studies, mixes outcomes or glissades over their clinical relevance. One such in *Bandolier* 71 is a review of music therapy for dementia. It concludes that music therapy helps. That's nonsense because there is no good evidence.
- 2 The review is great but the trials are awful. A superb review of randomised trials of ginseng demonstrates that almost no trials address the reasons why ginseng is used. Ginseng is used by the elderly. Most trials are in healthy youngsters: half are positive and half negative. No evidence for any effect.
- 3 The review is great, the trials are great, but they demonstrate conclusively that there is no effect. Another superb review examines homeopathy for migraine and headache prophylaxis. It doesn't work.
- 4 The review, despite comprehensive searching, finds no

trials of sufficient quality to be considered for analysis. There is just no evidence to say whether a therapy works or not. It's just a guess.

No double standards

Therapies, conventional or unconventional, must be judged against the same standards. Just in case anyone thinks *Bandolier* has a bias, in this issue we have two systematic reviews of interventions for prevention of postoperative nausea and vomiting. A conventional therapy, metoclopramide, is without any useful effect at conventional doses. An unconventional therapy, P6 acupressure stimulation, works.

Bandolier has previously pointed out that there is good evidence for the effectiveness of some alternative therapies, especially herbal remedies like St John's Wort for depression, Chinese herbal remedies for irritable bowel syndrome, and ginkgo and feverfew, for example.

There's no funding for research

Another one of those goalpost moving arguments. Most systematic reviews of conventional or unconventional therapy end with a plea for more research. That's usually valid, because one of the major benefits of the systematic review process is to shed a little light on what we don't know.

But there's little enough funding for any research. However, alternative therapy attracts large numbers of people who pay a lot of money for it. Why not a levy for funding good trials. Or why don't we have "loser pays" funding from research organisations. If a trial with agreed design and outcomes meets a certain level of clinical or statistical significance, the research organisation pays. If not, the organisation representing a particular interest group. Seems a fair idea, and the Dutch did it for iridology. cont... page 2

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The views expressed in Bandolier are those of the authors, and are not necessarily those of the NHSE

WHY BOGUS THERAPIES SEEM TO WORK

There is a great website (www.quackwatch.com) worth visiting if you are concerned about the benefits or otherwise of alternative therapies. One page is devoted to why “bogus” therapies seem to work. The points are well made and some apply just as much to conventional as alternative therapies. Most of the points are where non scientific belief can be nullified by proper scientific method.

That is the main reason why high quality studies of alternative therapies are negative, while lower quality studies are positive. If bias exists in the usual clinical situation, it is even more relevant for alternative therapies where belief in the value of the therapy is very strong.

Many diseases are self-limiting

The old saying is that a cold will go away in a week or in seven days if you treat it. Determining whether an intervention has made a difference is therefore difficult. Unless rigorous study methods are applied, an apparent benefit cannot be ascribed to the intervention or the natural course of the disease.

Many diseases are cyclical

Allergies, multiple sclerosis, arthritis and gastrointestinal problems like irritable bowel syndrome all have their ups and downs. Sufferers may seek therapy on a down, so that when an up comes that has to be due to the therapy, doesn't it. Again, only rigorous study design combats this.

Placebo effect

Both the above contribute to what is called a placebo effect. It can be seen as the natural course of things. For instance, some people need no pain relief after surgery [1], making a pre-emptive intervention which claims to reduce pain after surgery a sure win. There will always be some people publicly to declaim its value. Natural “placebo” rates depend on what the problem is and what the

benefit is. There will always be some people who benefit without an intervention.

Bets are “hedged”

“My auntie was under the doctor for six months, but it was only when she went started on homeopathy that she got better”. The fact that the poor infantry slaved away for six months is forgotten in the glamour of magic.

Original diagnosis may be wrong

Bandolier has highlighted the difficulty of diagnosis. If the diagnosis is wrong, then miraculous cures are less miraculous.

Mood improvement or cure

Alternative healers often have much more time to spend with their patient than a harassed GP loaded down with kilograms of guidelines and tight prescribing budgets. Is it any wonder that alternative healers can make patients feel better? That mood change is sometimes seen as the cure.

Psychological investment in alternatives

Alternative healing can be as simple as some herbal remedy bought from a shop. Sometimes it can involve huge amounts of time, massive involvement of the family, and an intense psychological investment in believing that something (anything) will work. It is not surprising, then, that many people find some redeeming value in the treatment.

Reference:

- 1 HJ McQuay, RES Bullingham, RA Moore, PJD Evans, JW Lloyd. Some patients don't need analgesics after surgery. *Journal of the Royal Society of Medicine* 1982 75, 705-708.

continued from page 1

Level heads

As an aid to demystification, we start this issue with a short step-by-step guide explaining why bogus therapies may appear to work. We also report on a study that pointed out that some trials from some countries, of conventional or unconventional therapies, appear to be universally positive. Negative outcomes just don't happen in China, Russia and a few other places.

Alternatives website

In the early part of 2000 we will build up a *Bandolier* Alternative Therapy website with the results of all the systematic reviews we can find. It's a lot of work, we have no fund-

ing for it, and offers of sponsorship would be welcome. We hope it will help patients and their carers in being a trusted source of useful information. It might even be useful for trading standards authorities.

Electronic update

Bandolier has to move from its present server. We are enormously grateful to those at the Oxford University Medical School who have helped over the last five years. A new home (or homes) is being sought, and we'll update you with developments.

ROUND THE WORLD WITH ACUPUNCTURE

Figure: Proportion of controlled trials of acupuncture showing superiority of acupuncture from five regions, with number of studies

Bandolier was a guest at a discussion on alternative medicine. One comment made was that “*The Chinese have been doing this sort of thing for thousands of years: surely it can’t be wrong?*” The immediate reaction was that the Chinese suffered to the same extent as everyone else to the great plagues of the 6th and 14th centuries, and Chinese historians record many, many major depredations over the centuries.

Perhaps it all comes down to how you look at things, standards set, and societal values. A systematic review [1] set out to answer the question whether some countries produce only positive results.

Search and inclusion

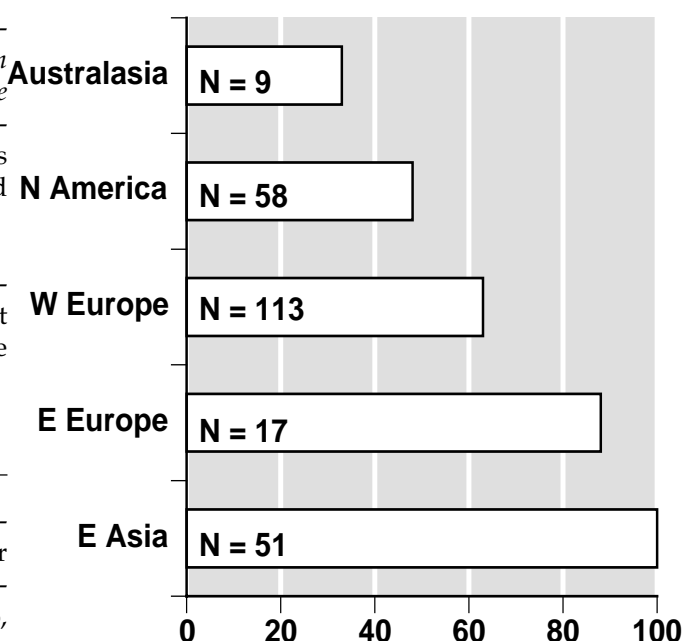
There were two searches. The first used MEDLINE to retrieve papers on acupuncture with abstracts available over 30 years. Papers had to have patients receiving acupuncture who were compared with patients receiving placebo, no treatment or a no acupuncture control.

The second search looked for randomised or controlled clinical trials published in China, Taiwan, Japan or Russia/USSR between 1991 and 1995. In addition, 330 most recent randomised or controlled trials published in England were sought. These studies had to have patients receiving a treatment other than acupuncture compared with patients receiving a control intervention.

Outcomes

Reviewers blinded to the country of origin then retrieved and abstracts examined. The outcome was a superiority of treatment over control based on:

- ◆ Author statement
- ◆ At least one statement of statistical superiority
- ◆ At least one outcome described as superior to control



Results

For acupuncture, there was a wide discrepancy between countries of origin and the proportion of trials showing superiority of acupuncture. Countries in North America, Western Europe and Australasia were positive for acupuncture about half the time, or less. Those from Eastern Europe and especially East Asia were positive nearly all the time (Figure).

The four countries which had 100% positive rates for acupuncture were compared with England for positive rates for randomised or controlled trials where acupuncture was not being tested. They also had very high rates of positive trials here as well (Table), as high as 97% for Russia/USSR and 99% for China. Rates for England were consistently lower.

Table: Proportion of trials with treatment better than control for randomised or controlled nonacupuncture studies, and from acupuncture studies, from five countries

Country	Randomised or controlled trials		Acupuncture trials	
	Number	Positive (%)	Number	Positive (%)
England	107	75	20	60
China	109	99	36	100
Japan	120	89	5	100
Russia/USSR	29	97	11	91
Taiwan	40	95	6	100

Comment

The authors of this review did a terrific job in trying to eradicate bias from their analysis. They acknowledge that because they included controlled trials, and looked only at abstracts, they will have included studies with known methodological bias. They also acknowledge that authors can and do make misleading or mistaken comments about trial results in abstracts.

That having been said, there remains a gulf between studies reported from different parts of the world. Bias may be institutionalised in some places, or may just be harder to detect in others. The reason randomisation schedules for patients are often described as being enclosed in metallised envelopes is because people have been known to X-ray envelopes to break the code before allocation.

The inference is obvious. Quality is much more important than quantity. No matter how many trials of inadequate or biased design we have, they do not match up to one trial of adequate size and methodological rigor. Quality is first, and everything else is nowhere.

"All was wrong because not all was right" is a useful quotation from George Crabbe that might usefully govern the interpretation of evidence. It applies to all therapies.

Reference:

- 1 A Vickers, N Goyal, R Harland, R Rees. Do certain countries produce only positive results? A systematic review of controlled trials. *Controlled Clinical Trials* 1998 19: 159-166.

NO EVIDENCE FOR MUSIC THERAPY FOR DEMENTIA

"...the published literature demonstrates that music/music therapy is an effective method overall for symptoms of dementia". This is the conclusion of a meta-analysis [1]. But is it right?

Methods

The search was extensive and looked at published studies in peer-reviewed journals that empirically addressed the use of music therapy for dementia. Twenty-one studies were included with study numbers from 3 to 40 patients. Twelve studies had fewer than 15 subjects, and only one had more than 30.

Result

Extensive and impenetrable statistical analysis concluded that music therapy was beneficial. What it was beneficial for was not stated specifically, but could have been as varied as agitation during bathing to sleeping.

Problem

There is no mention in the paper nor in the titles of the included papers, of the key words randomisation or blinding. Although we don't know it for a fact, it is highly likely that most of these studies were neither randomised nor blind.

In the absence of information on two of the most important sources of study bias, with more than half the studies with trivial size, with no stated outcome and no clear indication of the intervention, what can we conclude? Only that the conclusion of the meta-analysis is dangerous and probably wrong. At best we can conclude that there is no hard evidence that music therapy is of any value in dementia.

Reference:

- 1 SM Koger et al. Is music therapy an effective intervention for dementia? A meta-analytic review of the literature. *Journal of Music Therapy* 1999 XXXVI: 2-15.

NO EVIDENCE FOR GINSENG

Ginseng root extracts have been used for many centuries, and the claims for it are that it can improve vitality, immune function, and help in cancer, cardiovascular disease and sexual problems. It is a big business, with over \$100 million in sales in the USA a year, increasing at more than 25% a year. But does it work? A systematic review [1] concludes that the evidence is weak.

Search

This included several databases, hand searching, contacting manufacturers and experts in herbal medicine. Studies were included if they were randomised double-blind studies of ginseng mono-preparations, and for any indication.

Results

Sixteen studies met the inclusion criteria in a number of different indications.

Physical performance

There were seven trials, with 8-41 participants, all in healthy people, sportsmen or athletes with ages mostly under 40 years. Three of these found a statistical benefit for ginseng for some outcome, while four, the most recent, found none.

Psychomotor and cognitive function

There were five trials, with 19 to 127 participants. Four studies were in healthy volunteers, only one of which included people over 60 years. Three of these found a statistical benefit in favour of ginseng for at least one outcome like an arithmetic test. One study in elderly patients aged over 65 years found ginseng no better than control.

Immunomodulation

Two small studies examined the effects of ginseng on various immune-modulating factors in blood. One found changes, and one did not.

Diabetes

One small trial of 36 type-II diabetics found a significant improvement in glycosylated haemoglobin with ginseng.

Herpes

One study found a significant improvement in frequency, severity and duration of herpes episodes compared with placebo.

Comment

Most of the trials included in this review look methodologically sound. The problem is that in any one indication the weight of evidence is slight. Moreover, most ginseng is taken for indications other than those tested in these studies. There is no evidence, for instance, that ginseng slows the ageing process or helps mental or physical functioning in the elderly. Some of the findings probably deserve another look.

A real strength of this quality review is that it examined not only the good things that ginseng may bring, but also the bad. Information on adverse effects is extracted from the trials and commented on authoritatively, together with other evidence from the literature. Ginseng is not universally benign, and may be associated with quite severe adverse effects and some drug interactions.

Reference:

- 1 BK Volger, MH Pittler, E Ernst. The efficacy of ginseng. A systematic review of randomised clinical trials. *European Journal of Clinical Pharmacology* 1999 55: 567-575.

NO EVIDENCE FOR HOMEOPATHIC PROPHYLAXIS FOR MIGRAINE

The idea behind homeopathy is that the almost infinite dilution of a substance that causes a symptom will produce something with none of the original material remaining, but which can cure the symptom. Does this work for headaches and migraine? A systematic review of methodologically strong trials suggests that it does not [1].

Search

This was extensive, and used not only electronic searching of several databases, but hand searching of specialist journals and use of specialist databases. Four randomised, double-blind, placebo-controlled studies comparing homeopathic remedies with placebo were found.

Results

The three studies with the strongest methods showed no difference between homeopathy and placebo. One methodologically weak study did show a difference, and some de-blinding was reported to have been possible.

Comment

Bandolier visited the strongest of these trials before (*Bandolier* 46) and praised it. It is known that trials of poor reporting quality (as in the one positive study) can produce exaggerated treatment effects. What we have is this – that there is no evidence that homeopathy has any benefit for preventing migraine or headaches.

Reference:

- 1 E Ernst. Homeopathic prophylaxis of headaches and migraine? A systematic review. *Journal of Pain and Symptom Management* 1999 18: 353-7.

HERBAL THERAPIES AND SAFETY

People commonly deride alternative therapies as being ineffective, often followed up by an aside that “at least they are safe”. Not so. *Bandolier* has pointed out that there may be harm associated with acupuncture, for instance (*Bandolier* 68).

Herbal remedies have good evidence for efficacy. That is true of St John's Wort (*Bandolier* XX), feverfew (*Bandolier* ZZ) and ginkgo (*Bandolier* YY) if not ginseng (this issue). They are effective because they contain chemicals that interact with receptors or enzymes. Just as aspirin, morphine and cocaine are herbal derivatives with both good and bad effects, we should not be surprised that other herbal remedies may also have associated harm. A warning about the association of Chinese herbal remedies and renal failure was issued recently [1], with a reminder that yellow card reporting is important.

Adverse reactions to herbal medicines are not just due to the herbs themselves. Some preparations might contain other, toxic, herbs, heavy metals, or corticosteroids [1].

A review [2] examines a number of common herbal remedies. It provides no search strategy, though does include references to meta-analyses and systematic reviews, and to high-quality randomised clinical trials for efficacy. It gives information on the regulatory framework for herbal remedies. Most usefully it describes mechanisms of action, cautions, drug interactions and adverse effect information, and is well referenced. It is a worthwhile read for pharmacists and for those interested in herbal remedies.

Reference:

- 1 MCA/CSM. Current Problems in Pharmacovigilance. 1999 25 November.
- 2 TB Klepser, ME Klepser. Unsafe and potentially unsafe herbal therapies. *American Journal of Health-System Pharmacists* 1999 56: 125-38.

METOCLOPRAMIDE IS INEFFECTIVE IN PREVENTING POSTOPERATIVE NAUSEA AND VOMITING

Metoclopramide has been available for about 40 years, is cheap, and is widely used for treatment and prevention of nausea and vomiting. The implication, therefore, is that we must know all about it. There can be no surprises. Unfortunately for that cosy view of life, a meta-analysis [1] of metoclopramide for preventing postoperative nausea and vomiting shows standard doses to be all but useless.

Search

There was an intensive search of several electronic databases, hand searching, and contact with manufacturers. For inclusion studies had to be randomised comparisons of metoclopramide (any dose or route of administration) with placebo or no treatment, and in adults or children. Trials which treated established nausea and vomiting were not addressed in this review. Data was available in 66 randomised studies in which just over 3000 patients received metoclopramide and another 3000 patients received placebo.

Outcomes

The outcomes were nausea, vomiting or nausea and vomiting. These were examined early (0-6 hours) and late (0-48 hours) after surgery. These outcomes were examined for all trials, and for those where the incidence of nausea and vomiting with placebo fell within certain bands. These were 20-60% for early outcomes and 40-80% for late outcomes. Adults and children were treated separately.

Table: Main results from meta-analysis of metoclopramide compared with placebo for the prevention of postoperative nausea and vomiting

Dose/Route	Patients without	Time	Banding	Number of		Outcome with		NNT (95%CI)
				Patients	Studies	Metoclopramide (%)	Placebo (%)	
Adults								
10 mg iv	Nausea	Early	None	543	10	18	25	no benefit
	Vomiting	Early	None	538	9	20	31	9.1 (5.5 to 27)
	Nausea and/or vomiting	Early	None	881	14	32	42	10 (6.2 to 28)
10 mg iv	Nausea	Early	20-60%	298	5	28	36	no benefit
	Vomiting	Early	20-60%	355	7	21	30	11 (5.6 to 140)
10 mg iv	Nausea	Late	None	545	5	48	57	no benefit
	Vomiting	Late	None	728	8	39	48	10 (6 to 41)
	Nausea and/or vomiting	Late	None	297	6	49	62	7.3 (4.0 to 41)
10 mg iv	Vomiting	Late	40-80%	473	5	53	65	7.1 (4.4 to 19)
10 mg im	Nausea	Early	None	324	2	8	20	8.8 (5.3 to 26)
	Vomiting	Early	None	406	3	12	23	9.1 (5.5 to 28)
	Nausea and/or vomiting	Early	None	388	3	20	34	7.0 (4.4 to 18)
Children								
0.25 mg/kg iv	Vomiting	Early	None	510	7	31	48	5.8 (3.9 to 11)
0.25 mg/kg iv	Vomiting	Early	20-60%	409	5	29	41	7.9 (4.6 to 28)

Results

There was a variety of different doses and routes of administration. For many combinations, there was only a single trial. The average incidence of early nausea was 18% with placebo, with a wide range of 3 to 60%. The average incidence of early vomiting with placebo was 31% with a range of 18 to 96%.

The main results, where there were at least three trials or 300 patients, are shown in the Table. In all cases the number needed to treat to prevent one additional case of nausea, vomiting or nausea and/or vomiting was 7 and above for adults and 6 and above for children. There was no evidence of a consistent dose-response.

Adverse effects were extracted from the trials. There was no evidence of a greater incidence of extrapyramidal symptoms, sedation and drowsiness, dizziness and vertigo or headache with metoclopramide at these doses than with placebo.

Comment

This is a fine review. It shows evidence of lack of any clinically significant antiemetic effect of metoclopramide in preventing postoperative nausea and vomiting at standard doses. Given that metoclopramide is widely used for this indication, it suggests that a lot of money is being wasted on an ineffective dose.

That conclusion depends, of course, on the definition of clinical usefulness. This group has previously defined a clinically useful result and a number needed to treat of 5 or below. Metoclopramide could not achieve this benchmark for any combination of dose, outcome in adults or children

where there was a worthwhile amount of data. We define this as at least three trials and /or 300 patients studied. Even where point estimates approached 5, the confidence intervals were wide.

Reference:

1 L Henzi, B Walder, MR Tramèr. Metoclopramide in the prevention of postoperative nausea and vomiting: a quantitative systematic review of randomized placebo-controlled studies. British Journal of Anaesthesia 1999 85: 761-71.

NON-PHARMACOLOGICAL TECHNIQUES
PREVENT POSTOPERATIVE NAUSEA
AND VOMITING

The P6 acupuncture point lies about four centimetres up the arm from the wrist creases. Stimulation of this point is claimed to reduce nausea and vomiting effectively. A systematic review [1] comes to the conclusion that stimulation of the P6 point is indeed effective in preventing postoperative nausea and vomiting in adults, but not in children.

Search

There was an extensive search for randomised trials, including electronic databases and a specialist acupuncture database. To be included trials had to have a non-pharmacological technique that stimulated the P6 point to prevent postoperative nausea and vomiting. Trials that treated established nausea and vomiting were not addressed. There were 19 randomised studies with 1679 patients, of whom 739 were given P6 stimulation. Four studies were in children.

Outcomes

The outcomes were nausea, vomiting or nausea and vomiting. These were examined early (0-6 hours) and late (0-48 hours) after surgery. Adults and children were treated separately.

Table: Main results from meta-analysis of P6 acupuncture point stimulation compared with sham acupuncture for the prevention of postoperative nausea and vomiting

Patients	Patients without	Time	Number of		Incidence with		NNT (95%CI)
			Patients	Studies	P6 stimulation (%)	Placebo (%)	
Adults	Nausea Vomiting	Early	421	7	17	38	4.8 (3.4 to 8.1)
		Early	610	9	15	33	5.5 (4.0 to 8.8)
	Nausea Vomiting	Late	187	3	13	40	3.6 (2.5 to 6.5)
		Late	290	4	18	27	no benefit
Children	Vomiting	Late	189	3	52	48	no benefit

Results

Sham acupressure or no treatment were the predominant controls. Active treatments were manual rotation of needles, electrical stimulation of needles, semipermanent needles, transcutaneous electrical stimulation and acupressure. All activated the P6 acupuncture point.

For adults, P6 acupuncture point stimulation halved the incidence of early postoperative nausea and vomiting with numbers needed to treat of about 5 (Table, Figure). Five patients would require acupuncture point stimulation to prevent postoperative nausea and vomiting in one of them. One trial with 200 patients looked at nausea and/or vomiting over six hours, and this too had an NNT of about 5.

For adults, the incidence of late nausea was reduced by P6 acupressure stimulation, with an NNT of about 4. Though there was a reduction in the incidence of late vomiting by about 10%, this did not achieve statistical significance.

For children the only useful data was for the prevention of late vomiting. Here P6 acupuncture point stimulation was without effect. There was no evidence for early effects of P6 stimulation for children in two trials.

Comment

P6 acupuncture point stimulation was effective in preventing postoperative nausea and vomiting in adults though not in children. *Bandolier* has made one small change in the review, judging one study which had 0-8 hour outcomes as closer to early outcomes (0-6 hours) than late outcomes (0-24 hours). It made no significant change to the results. The interesting point is that the estimate of efficacy, with NNTs of about 5, is within the borders of a size of a clinical effect judged to be worthwhile. It is also interesting that in the same setting we have the evidence of efficacy favouring an alternative therapy over a much-used pharmacological therapy, metoclopramide at a dose of 10 mg.

Reference:

1 A Lee, ML Done. The use of nonpharmacological techniques to prevent postoperative nausea and vomiting: a meta-analysis. Anesthesia and Analgesia 1999 88: 1362-9.

While humbug may mean misleading behaviour (or talk) which is intended to win support or sympathy to some, to others it will always be a hard-boiled sweet. Rationing has to be, to maximise the health of the population served when resources are limited (as *Bandolier* has argued before in issues 2 and 8). The humbug comes in the process. *Bandolier* believed that closing mental hospitals was for the good of the patients (*Bandolier* was 'humbugged'). NHS dentistry, for many at least, just disappeared. Care of the elderly quietly went from being covered by the state to not being covered. What happened to our involvement in these decisions, professional or as citizens? Were we just asleep, or were we humbugged by a process which passed us by?

The fourth hurdle for new drugs, the cost-effectiveness investigations by the National Institute of Clinical Excellence (NICE), is at least an attempt to make overt judgements about medical interventions, and we should welcome it. In *Bandolier* 69 we covered their studies of Relenza, the anti-flu symptom drug. Clearly the drug works: the argument is about how well it works, particularly in high-risk groups. But if an articulate patient arrives with flu in the surgery and demands Relenza what happens? By some quirk of the GP contract does the patient have the right to be prescribed the drug? Does the GP have the right to override NICE?

The MDU said yes (15/9/1999) "GPs will neither lose their clinical freedom nor be able to set aside their clinical judgement when NICE guidance comes into force. GPs have a legal, contractual and ethical duty to act in the best interests of the patient. This clearly involves taking into account national guidance on recommended treatment but, if a GP decides that a recommended treatment is not in a particular patient's best interests, then he must act as he thinks is right for that patient."

The last piece of New Year humbug is the claim that the NHS is cheap, with Britain spending less than 7% of GDP, much less than other developed countries. *Bandolier* worries that while in other countries the ramifications of chronic illness are overtly badged under the spending on health, here we badge them differently. Could it be that our actual health spend is not so very much lower than the other countries, that our quality may be lower than we would like, and that we need a radical re-think? It would be tragic if current media doctor-bashing (self-inflicted as it may be) allowed such a radical re-think without the profession's involvement. Protection from humbug is what we need.

John Diamond "C Because cowards get cancer too..." Vermilion London 1998 ISBN 0-09-181665-3 pp256 £6.99

Late in the day, because it seemed too much like work, *Bandolier* came to John Diamond's C. It is a highly articulate and intelligent account of life with throat cancer. A friend used to tell me that he hated lying interminably on the examination couch while the doctor washed his hands. The doctor wouldn't pronounce on recurrence or not till the hand washing ritual was complete. You alter your practice. This book has similar insights, but above all the importance of good team work in chronic illness was reinforced, so that the adverse effects of treatment are dealt with effectively and don't impinge unnecessarily on remaining time.

Bandolier heartily recommends what John Diamond writes about alternative medicine and the anti-medical lobby. He classifies those who wrote to him as Benign (gentle nudgers) or Malignant (demanders). He then breaks each of these into a further three groups, the religious, the alternative medicine aficionados and "those who admitted to knowing nothing about science but who knew that homeopathy had worked when their husband had cancer in 1987". John Diamond found the latter the toughest to deal with. Quackwatch.com may give the intellectual rebuttal, but that's little help in the clinic. The importance of being able to rebut "known facts" which are completely untrue is the opportunity cost - fine if the alternative makes people feel better with no adverse effects, not fine if they deny themselves effective treatment to pursue the alternative.

John Bayley "Iris A memoir of Iris Murdoch" Abacus London ISBN 0 349 11215 0 pp294 £7.99

Another wonderful book. John Bayley's account of caring for Iris Murdoch is warm and sad. You get a feel of the burden of coping with the repeated question, the following around the house, using daytime television to distract. All this against a backdrop of an unusual alliance, with the shared history lost as the disease takes its course. Gillian Ford at Marie Curie used to talk about the impact of the collapse of informal care, frail carers and demography on our society. Understanding and supporting the carer and spotting the point at which the situation is no longer tenable can be difficult. This memoir has great insight.

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More details on *Bandolier* Internet site